PRINTED: 03/08/2011 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				0.	MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATI	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155199	B. WIN			02/10/	2011
		1	D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			JNION ST		
MAPLE I	PARK VILLAGE				FIELD, IN46074		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	i		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	BE	COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE	DATE
F0000	This visit was for a Recertification and State Licensure Survey.		F0000		The creation and submission of Plan of Correction does not constitute an admission by this		
	Survey dates: F			provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.			
	Facility number:						
	Provider number: 155199				This provider respectfully req		
	AIM number:	100266390			that the 2567 plan of correction considered the letter of credib		
					allegation and request a desk		
	Survey team:				in lieu of a Post Survey revisit		
	Diana Zgonc RN	N TC					
	Connie Landma						
	Courtney Hamil						
	Christi Davidson						
	Cillisti Daviusoi						
	Census bed type						
	SNF/NF:	73					
	SNF	9					
	Total:	82					
	Total.	02					
	Census payor ty	pe:					
	Medicare:	14					
	Medicaid:	48					
	Other:	20					
	Total:	82					
	Total.	02					
	Sample:	17					
	These deficienci	ies also reflect state					
		accordance with 410 IAC					
	16.2.	accordance with 410 1/10					
	10.2.						
	Ouality review a	completed 2/18/11 by					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RWGY11

Facility ID:

000106

TITLE

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155199	A. BUILDING		02/10/2011
		133199	B. WING		102/10/2011
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE JNION ST	
	PARK VILLAGE		WESTF	FIELD, IN46074	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
IAG			IAG	BEI ICERCI)	DATE
	Jennie Bartelt, R	.IN.			

F0282 Based on observation, record review and interview, the facility failed to ensure residents with physician orders for blood pressures were obtained for 2 of 17 residents reviewed for following physician orders in a sample of 17 (Residents #23 and #44) and failed to ensure residents received only medications ordered by the physician for 1 of 17 residents reviewed for medication orders (Resident #71), and failed to ensure residents with orders for respiratory nebulizer treatments were administered the treatments by a licensed nurse for 2 of 3 observed for nebulizer treatment (QMA #1,	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COMPL	(X3) DATE SURVEY COMPLETED 02/10/2011	
F0282 Based on observation, record review and interview, the facility failed to ensure residents with physician orders for blood pressures were obtained for 2 of 17 residents reviewed for following physician orders in a sample of 17 (Residents #23 and #44) and failed to ensure residents received only medications ordered by the physician for 1 of 17 residents reviewed for medication orders (Resident #71), and failed to ensure residents with orders for respiratory nebulizer treatments were administered the treatments by a licensed nurse for 2 of 3 observed for nebulizer treatment (QMA #1, p. 1/10/6/).	MAPLE	PARK VILLAGE		776 N UNION ST					
review and interview, the facility failed to ensure residents with physician orders for blood pressures were obtained for 2 of 17 residents reviewed for following physician orders in a sample of 17 (Residents #23 and #44) and failed to ensure residents received only medications ordered by the physician for 1 of 17 residents reviewed for medication orders (Resident #71), and failed to ensure residents with orders for respiratory nebulizer treatments were administered the treatments by a licensed nurse for 2 of 3 observed for nebulizer treatment (QMA #1,	PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI	E	COMPLETION DATE	
Regarding resident 71, the physician was contacted the telephone order was rewritten. The physician examined the resident and made a note in the medical record. The telephone order was sent to the pharmacy to be added to the next month's recap of orders. Regarding resident 110 and 96, the Qualified Medical Assistant (QMA) was counseled on 2/9/11 and educated on the QMA scope of practice. How will you identify other residents having the		Based on obserview and intraled to ensure physician order pressures were residents reviewed for the ensure residents #22 to ensure residents for reviewed for reviewed for reviewed for residents with nebulizer treat administered to the ensure residents with nebulizer treat administered to the ensure residents #11 sample of 17. Findings inclusion. 1. The record reviewed on 0. Diagnoses for the ensure residents with the ensure residents #11 sample of 17.	ervation, record terview, the facility re residents with ers for blood e obtained for 2 of 17 ewed for following ers in a sample of 17 3 and #44) and failed dents received only rdered by the 1 of 17 residents medication orders), and failed to ensure orders for respiratory tments were the treatments by a e for 2 of 3 observed treatment (QMA #1, 0 and #96) in a and the control of the facility the resident #23 was 12/07/11 at 1:50 P.M.	F02		F282 Service by qualified persons/per care plan This provider ensures the services provided or arrange the facility are provided by qualified persons in accorda with each resident's written of care. What corrective action(s) will be accomplist for those residents found thave been affected by the deficient practice Regardin resident 23, the physician we contacted and blood pressure orders were changed to be monitored weekly. Regardin resident 44, the physician we contacted; medication dosas were changed as well as bloop pressure monitoring orders. Regarding resident 71, the physician was contacted the telephone order was rewritted. The physician examined the resident and made a note in medical record. The telephor order was sent to the pharm to be added to the next more recap of orders. Regarding resident 110 and 96, the Question Medical Assistant (QMA) was counseled on 2/9/11 and educated on the QMA scope practice. How will you identiced.	ed by ince plan hed io g as re g as ges ood en. e the acy ath's alified as e of tify	03/08/2011	

STATEMEN	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (ULTIPLE CO	CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155199	B. WIN			02/10/2011	
			1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			776 N L	JNION ST		
	PARK VILLAGE				FIELD, IN46074		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)	1	TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	\	high blood pressure),			potential to be affected by th same deficient practice and	e	
dementia, hemorrhagic cerebral					what corrective action will be	,	
vascular accident with right				taken All residents with orders	l l		
		sphagia, depression			routine blood pressure's chart		
					were audited any issues identi	fied	
	and hyperlipid	cima (iligii			of residents lacking blood pressures as ordered, the		
	cholesterol).				physician was contacted as		
					appropriate. All recaps and		
	The February	2011 recapitulation			medication administration she		
	1	current physician's			were audited for accuracy; iss	ues	
		ed the resident was			identified were addressed appropriately. A 1:1 inservice v	was	
					provided for the QMA regarding		
	ı	edicine for HTN			the facility policy for procedure		
	(hypertension)	, amlodipine besylate			that can be completed by a QI	MA	
	10 mg (millign	ram), tablet once a			and the Indiana standard for QMAs. No residents were		
	day originally	ordered on 09/02/10.			affected as the resident identif	ied	
		it was indicated			administers her own nebulizer		
	_	vas receiving a			medication. What measures v	vill	
					be put into place or what		
	second medica	,			systemic changes you will make to ensure that the		
	Labetalol Hl 1	00 mg tablet two			deficient practice does not		
	times a day or	iginally ordered			recur The facility has a		
	09/02/10.				scheduled day of the week to		
					obtain weekly blood pressures	i.	
	The room in 4:	cated a current			An inservice was provided regarding blood pressure		
	1				monitoring and documentation	i to	
		ler originally dated			include the assigned schedule	for	
	09/01/10, "Ch	eck blood pressure			monitoring was discussed with	ı	
	every week on	: Thurs 7-3 Call			the licensed staff and QMAs. Weekly blood pressures are		
	· ·	(blood pressures) 1			assigned on the MAR, and will	lbe	
					documented on the MAR and/		
	HR (hour) apart are out of range:				in the nurse's notes as		
	515 (Systolic)	(greater than) 200			appropriate. Medications with		
					hold orders for blood pressure		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPL	
		155199	B. WIN	IG		02/10/2	011
NAME OF	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP CODE		
				1	JNION ST		
MAPLE I	PARK VILLAGE			WESTF	FIELD, IN46074		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	(less than) 90,	DIAS (diastolic)			readings will be documented separately on the MAR and		
	(greater than)	100, (less than) 50."			scheduled/completed prior to t	he	
					medication administration. Uni		
	The Medicatio	on Administration			Managers were inserviced on		
					completion of recaps, MARs a	and	
	`	a), dated 01/01/11			TARs All QMAs and licensed		
	through 01/31	/11, indicated			nurses were inserviced on the QMA scope of practice and the		
	Resident #23	received amlodipine			facility guidelines for QMAs. S		
		dered at 6:00 A.M.			validations were completed or		
	1 *				QMAs for medication		
	everyday the entire month of				administration. How the		
	January 2011.				corrective action(s) will be		
					monitored to ensure the deficient practice will not rec		
	The MAR dat	ted 01/01/11 through			i.e., what quality assurance	·ui,	
	·	cated Resident #23			program will be put into plac	е	
	•				The DNS/Designee will be		
		talol HCl 100 mg			responsible for monitoring for		
	tablet as order	red at 6:00 A.M. and			compliance by conducting a		
	8:00 P.M. the	entire month of			weekly audit of the residents v orders for weekly blood	vitn	
	January 2011	except at 6:00 A.M.			pressures. This will continue to	for	
	on 01/25/11.	except at 0.00 min.			60 days then frequency will be		
	011 01/23/11.				determined by the CQI team. I		
					those residents with daily bloo	d	
	The MAR, da	ted 01/01/11 through			pressure orders, the DNS/Designee will review for the control of t	the	
	01/31/11, for 1	Resident #23, lacked			presence of the appropriate bl		
	ĺ	n. Blood pressure			pressures at least 3 times wee		
		•			for 60 days then frequency wil	•	
	readings were	missing.			determined by the CQI team.	•	
					issues identified will be called		
	The Monthly	Vital Sign Monitoring			the MD as needed; re-inservice training/disciplinary action will		
	1	ent #23, dated 2011			imposed as appropriate. Skills		
	1	, aatod 2011			validations will be completed by		
	was blank.				the SDC/Designee during rand	dom	
					medication passes with a QM/		
					least 3 times weekly for 4 wee	KS,	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED		
		155199	B. WIN			02/10/20	11	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER	S.		1	JNION ST			
MAPLE F	PARK VILLAGE			1	FIELD, IN46074			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	A nurse's note	, dated 01/05/11, at			then weekly for 4 weeks, then	as		
9:00 P.M., indicated the resident's				determined by the CQI team. Recaps will be signed as				
	blood pressure				accurate by the licensed nurse	_		
	biood pressure	was 115/70.			The Pharmacist will complete	·		
					another review of the recap			
	A nurse's note	, dated 01/24/11, at			monthly for a double check for			
	6:00 P.M., ind	icated the resident's			accuracy of recap. Results of			
	blood pressure				audits will be discussed in the Monthly CQI meeting for quali			
	Jiood probbare	1=> 01.			assurance Compliance date:			
	0.00/00/11	. 5.05 P. 1.1. 1		March 8, 2011				
	· ·	at 5:05 P.M., blood						
	pressure reading	ngs were requested						
	for 01/13/11 a	nd 01/20/11, which						
		d and third week of						
		e end of the day						
	**	e end of the day						
	conference.							
	On 02/09/11, a	at 8:43 A.M., no						
	blood pressure	e recordings for						
	_	/20/11 were provided						
		nt Director of Nursing						
	*	•						
	·	other blood pressure						
		anytime between						
	01/05/11 and (01/24/11 were						
	provided by th	ne ADON.						
	_							
	On 02/09/11	at 10:40 A.M., during						
	· ·	, ,						
		vith LPN #10, it was						
	indicated that	blood pressures are						
	recorded on th	e MAR, The Monthly						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			I	E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	!!	1	STREET A	IDDRESS, CITY, STATE, ZIP CODI INION ST IELD, IN46074	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Vital Sign Mo	nitoring Log, or in tes.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155199			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER		'	776 N L	ADDRESS, CITY, STATE, ZIP CODE JNION ST FIELD, IN46074	•	
	PARK VILLAGE SUMMARY S (EACH DEFICIEN REGULATORY OR 2. A current facil ADON on 02/10, "General guidelin medications" and indicated, " The MAR and note at and or other pertimate of the same dication." Record review of reviewed on 02/0 Diagnoses include to, hypertension, ulcers. Current physician order, originally Lisinopril (blooding (milligrams) day. Hold for SB pressure) less that The medication at (MAR) lacked dot #44's BP had been seguing the summary of the summary of the summary of the medication at (MAR) lacked dot #44's BP had been seguing the summary of th	ity policy provided by the // 11 at 8:45 A.M. titled, nes for administering I dated 01/01/05 e nurse will review the ny allergies, side effects inent information that fe administration of the If Resident #44 was 07/11 at 2:30 P.M. Idd, but were not limited neuropathy, and pressure In's orders indicated an ordered on 11/22/10, for pressure medication) 40 2 tablets orally once a P (systolic blood in 120. Indiministration record ocumentation Resident in checked prior to ithe Lisinopril from	F02	776 N U WESTF ID PREFIX TAG	JNION ST	I by ce an ed second	(X5) COMPLETION DATE 03/08/2011
	Manager #9 on 0	iew with the Unit 2/09/11 at 10:25 A.M., P's "were not in the			Medical Assistant (QMA) was counseled on 2/9/11 and educated on the QMA scope of practice. How will you identified their residents having the	of	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION		A. BUI	LDING		
		155199	B. WIN	IG		02/10/2011
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	
	, IBER OR OUT EIER			1	UNION ST	
	PARK VILLAGE				FIELD, IN46074	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		urses notes, then there			potential to be affected by th	e
	aren't any [sic]."				same deficient practice and what corrective action will be	
					taken All residents with orders	
	During daily con	ference on 02/09/11 with			routine blood pressure's chart	· .
	" "	r, DON (Director of			were audited any issues ident	
		OON (Assistant Director			of residents lacking blood	
	"	ident #44's daily BP			pressures as ordered, the	
		· ·			physician was contacted as	
	1 ^	uested. On 2/10/11 at			appropriate. All recaps and	
	l '	DON indicated, "we do			medication administration she	l I
not have any daily blood pressures."					were audited for accuracy; iss	ues
					identified were addressed appropriately. A 1:1 inservice	was
3. The record for Resident #71 was				provided for the QMA regarding		
	reviewed on 2/7/11 at 2:50 P.M.				the facility policy for procedure	~ I I
					that can be completed by a QI	
	Current diagnose	es included, but were not			and the Indiana standard for	
		sis, hypothyroidism,			QMAs. No residents were	
					affected as the resident identif	l I
	_	res, gastroesophageal			administers her own nebulizer	
	I	rial fibrillation, and			medication. What measures v	vIII
	atypical psychosi	is.			be put into place or what systemic changes you will	
					make to ensure that the	
	Resident #71's pa	ain assessment, dated			deficient practice does not	
	12/9/10, indicate	d the resident received			recur The facility has a	
	1	ol - a pain medication)			scheduled day of the week to	
	`	ams) three times a day.			obtain weekly blood pressures	s.
		and, three threes a day.			An inservice was provided	
	Dogidant #711c E	obmiomi 2011			regarding blood pressure	,
	Resident #71's Fe	•			monitoring and documentation	
		physician's orders lacked			include the assigned schedule monitoring was discussed with	
	a printed order for				the licensed staff and QMAs.	'
	administered. Th	ne order was handwritten			Weekly blood pressures are	
	in.				assigned on the MAR, and wil	l be
					documented on the MAR and/	or
	The November 2	010, December 2010,			in the nurse's notes as	
		d February 2011, MARs			appropriate. Medications with	
	2011, 411	2011, 11111110			hold orders for blood pressure	
					Į.	

			ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED
		155199	B. WIN	IG		02/10/2011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
	NO VIDEN ON SOLVEN				JNION ST	
	PARK VILLAGE			WESTF	FIELD, IN46074	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	`	inistration records)			readings will be documented separately on the MAR and	
	indicated the ord	er for Tramadol	scheduled/completed prior to the			the
	handwritten in, and administered 3 times				medication administration. Uni	I
	a day.				Managers were inserviced on	.
					completion of recaps, MARs a	and
	During the daily	conference with the			TARs All QMAs and licensed	
	-	ssistant Director of			nurses were inserviced on the	
		(ADNS), and Consultant			QMA scope of practice and the	
	_	` //			facility guidelines for QMAs. S validations were completed or	I
		at 4:15 P.M., information			QMAs for medication	ı alı
	concerning an order for the use of Tramadol was requested.			administration. How the		
					corrective action(s) will be	
					monitored to ensure the	
	During the daily	conference with the			deficient practice will not rec	eur,
	Administrator, D	NS, ADNS, and Nurse			i.e., what quality assurance	
	Consultant on 2/8	8/11 at 5:00 P.M., the			program will be put into plac	e
		she was unable to find an			The DNS/Designee will be	
	order for the Trai				responsible for monitoring for	
	order for the fran	iliudoi.			compliance by conducting a weekly audit of the residents v	vith
	Duning on interni	ious swith I DNI #2 on			orders for weekly blood	VIIII
	_	iew with LPN #3 on			pressures. This will continue t	for
		A.M., she indicated there			60 days then frequency will be	,
	wasn't a signed (l				determined by the CQI team. I	
	-	physician's orders with			those residents with daily bloo	od
	the order for the	Tramadol written in.			pressure orders, the	the
					DNS/Designee will review for to presence of the appropriate bl	• • • • • • • • • • • • • • • • • • •
	4. The Indiana A	Administrative Code,			pressures at least 3 times wee	
		Qualified Medication			for 60 days then frequency wil	· 1
	Aides 412 IAC	•			determined by the CQI team.	Any
		e 6 (b) (2) indicated:			issues identified will be called	
		ng tasks shall not be			the MD as needed; re-inservic	• • • • • • • • • • • • • • • • • • •
	` '	MA scope of practice:			training/disciplinary action will	
					imposed as appropriate. Skills validations will be completed by	
	(2) Administer medication used for intermittent positive pressure breathing			the SDC/Designee during rand	, ,	
					medication passes with a QM/	
	(IPPD) treatment	ts or any form of			least 3 times weekly for 4 wee	• • • • • • • • • • • • • • • • • • •

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155199		LDING		02/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1	JNION ST		
	PARK VILLAGE			WESTF	TELD, IN46074		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	`				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	
(X4) ID PREFIX TAG	medication inhal than metered dos 5. The record for reviewed on 2/9/ Current diagnose limited to, paner obstructive pulm hypertension, and A current physic indicated Duone be inhaled by ne During an observon 2/8/11 at 3:25 observed starting for Resident #11 returned to the h facility corporation to perform nebul sometimes did, at later to check the observation of the P.M. and Reside in the bathroom nurse was observed #110's room to consider the consideration of th	lation treatments, other se inhaler" or Resident #110 was //11 at 9:00 A.M. es included, but were not eatic cancer, chronic nonary disease,		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	as e. the	COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/10/2011	
	PROVIDER OR SUPPLIER		776 N U	ADDRESS, CITY, STATE, ZIP COD JNION ST FIELD, IN46074	DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	limited to, gastro disease, chronic disease, and asth	es included, but were not besophageal reflux obstructive pulmonary ma.					
		rol 0.083% solution 3 ml d by nebulizer 4 times a					
	observed handing medication for he QMA #1 indicate #96 was able to of treatment, which	2/8/11, QMA #1 was g Resident #96 the er nebulizer treatment. ed at that time Resident do her own nebulizer the resident proceeded to ent of this resident other ration was done.					
	2/9/11 at 9:55 A. licensed nurses d QMA's are not al corporation. But taught to do thing continue to do the	iew with LPN #3 on M., she indicated lo nebulizer treatments, llowed by the a sometimes QMA's are gs in other facilities and em in this facility even oration says they can't.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 02/10/2011		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
155199			B. WING 02/10/20			02/10/2011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER				JNION ST	
MAPLE F	PARK VILLAGE			l	FIELD, IN46074	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
F0371	Based on observa	ation, record review and	F03	71	F371 Food storage/prepare/serv	e – 03/08/2011
	interview the fac	ility failed to ensure			sanitary conditions	1
	residents would b	be free from the potential			The facility does store, prepare ar serve food under sanitary condition	
	of a foodborne il	lness due to the lack of			serve rood under samtary condition	J115.
	proper handwash	ing and due to the lack of				
	proper food hand	_				
	residents. (Dieta	_			What corrective action(s) will b	l l
	,	Cook #6) (Cook #7) (CNA			accomplished for those residents	
	#8)	00k #0) (COOK #1) (CNA			found to have been affected by t	he
	#0)				deficient practice	
	D: 1: : 1 1				There were no residents identified	1 25
	Findings include				affected in the 2567.	1 43
		cy titled "American			How will you identify other	
	Senior Communi	ties Hand Washing,"			residents having the potential to	be
	dated 05/06, prov	vided on 02/09/11, at			affected by the same deficient	
	8:43 A.M., by the	e ADON (Assistant			practice and what corrective	
	Director of Nursi	ing), indicated, "Dietary			action will be taken	
	staff will wash ha				All residents have the potential to	, he
	touchingequipr	nent, or utensils;before			affected. No residents were	
	touching food or				identified in the 2567.	
	_	er engaging in other				
		ntaminate handsWash			What measures will be put into	
					place or what systemic changes	
	for at least 20 sec	conus			you will make to ensure that the	I
					deficient practice does not recur	
	• •	cy titled "American			An inservice was provided regard	ling
		ities General Food			hand washing and food handling	-
	•	Handling," dated 09/08,			the facility staff.	
	provided on 02/0	9/11, at 8:43 A.M., by			_	
	the ADON, indic	ated, "Food items will be			Hand washing skill validations w	ere
	prepared tobe f	ree of injurious			completed on all dietary staff to	
		ibstancesFood will be			ensure that handwashing occurs f	or
	_	ved with clean tongs,			at least 20 seconds per facility	
	* *	atulas, or other suitable			policy.	
	Torks, spoons, sp	araido, or ourer surmore				

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
THETETAL	155199		A. BUILDING			02/10/2011	
		100100	B. WIN		ADDRESS OWN STATE THE CODE	02/10/2011	
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE UNION ST		
MAPLE F	PARK VILLAGE				FIELD, IN46074		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	implements so as	s to avoid manual contact			Handwashing/infection control		
	of prepared food	sBare hands should			practices are discussed with all nemployees upon hire per the general	l l	
	never touchread	dy to eat food			orientation program.	ziai	
		ngs when serving rolls,			orientation program.		
	"				Skills validations will be conduct	ted 3	
					times weekly during random		
	3. On 02/07/11,	at 11:10 A.M., Cook #6			meals/tray pass, any issues will b	e	
	was observed lea	ving the steam table and			addressed with additional 1:1 education/disciplinary action as		
	entering the dry s	storage area. She			appropriate		
	returned to the fo	ood preparation line and			upp-spsssss		
		She then retrieved a					
	-	m a drawer and then					
	•	rowave. She did not					
	•	She returned to the					
	steam table to pla				How the corrective action(s) wil	,	
	steam table to pro	1004.			be monitored to ensure the		
	4 On 02/07/11	at 11:15 A.M., Cook #6			deficient practice will not recur-	,	
		cking up a corn muffin			i.e., what quality assurance		
	•	nd from the steam table.			program will be put into place		
		he tongs for one muffin			A CQI audit for meal service, to		
		ne tongs for one marrin			include handwashing will be		
	that she plated.				completed by the Dietary Service		
	5 0= 02/07/11	ot 11,20 A.M. Distric			Manager/Designee at least 3 times		
	· ·	at 11:20 A.M., Dietary			weekly for 60 days then as		
	_	observed with 12 second			determined by the members of th	e	
	handwashing in t	the kitchen.			CQI team.		
	6 On 02/07/11	at 11:25 A.M., Dietary			Any trends identified will be		
	· ·	observed with 10 second			discussed with the CQI team for		
	handwashing in t				recommendations for appropriate	·	
	nanuwasiiiig iii t	HE KILCHEII.			actions		
	7 On 02/08/11	at 6:00 P.M., Cook #7			The corrective action will be		
	· ·	oositioning the steam			monitored by the Dietary service		
		ng in the cord of the			Manager.		
	more and pruggin	is in the cold of the			Compliance date: March 8, 201	ıı	
					• • • • • • • • • • • • • • • • • • • •		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP: 02/10/2	LETED	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET A 776 N U	ADDRESS, CITY, STATE, ZIP CODE JNION ST FIELD, IN46074		
MAPLE F (X4) ID PREFIX TAG	summary s (EACH DEFICIEN REGULATORY OR steam table into thands. She did r began serving fo 8. On 02/08/11, Manager #4 was kitchen and enter a thermometer. with an alcohol s her hands. She i into the beef and hovering over the thermometer wit inserted the therr	the wall outlet with bare not wash her hands. She od from the steam table. at 6:00 P.M., Dietary observed exiting the ring the dining area with She cleaned thermometer wab. She did not wash inserted the thermometer noodles with her hand e food. She cleaned the han alcohol swab and mometer into the her hand hovering over	I		D BE	(X5) COMPLETION DATE
	interviewed regated for kitchen hands she should wash or exiting the kit should wash her On 02/08/11, at observed grabbin rolling trash cart hands. She then	in the facility policy washing. She indicated her hands when entering chen. She indicated she hands for 20 seconds. in the facility policy washing. She indicated she hands for 20 seconds. in the handles of the she handles of the she did not wash her proceeded to serve trays forward" dining area.				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	li i	E SURVEY PLETED /2011		
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA (X2) M		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
155199		B. WING		02/10/2011				
		II.	D. (111)		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L.			JNION ST			
MAPLE F	PARK VILLAGE			I	FIELD, IN46074			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0425	Based on observa	ation, interview, and	F04	25	F 425 Pharmaceutical services.		03/08/2011	
SS=D	record review, th	e facility failed to ensure			The Carity days are 11.			
	that expired med	ications were disposed of			The facility does provide pharmaceutical services, includin	σ.		
	•	lity policy after the			procedures for acquiring, receivir	-		
	•	or 6 of 6 medication carts			dispensing and administration of			
	-	ired medications. The			drugs to meet the needs of the			
	•	e affected 1 of 17 sampled			residents.			
	•	•						
	residents. (Resid	ient #21).						
					What corrective action(s) will be			
	Findings include	:			accomplished for those residents			
					found to have been affected by t	he		
	Current facility policy titled, "Expiration d				deficient practice			
	-	cation" dated 01/01/05,			Regarding resident 21, the			
		ON (Assistant Director of			medication was disposed, and			
		11 at 8:40 A.M., indicated, s with intact integrity should be			reordered from the pharmacy			
		sident." The policy also			• •			
		ophthalmic solution container						
		within six weeks of removal			How will you identify other			
	from sealed pouch."				residents having the potential to	be		
	•				affected by the same deficient			
	Current facility r	policy titled, "General			practice and what corrective action will be taken	rrective		
		ministering medication"			action will be taken			
	•	provided by the ADON			The surveyor went through all 6			
		•			medication and treatment carts pe	er		
		45 A.M., indicated "if			the 2567 and no other residents w			
		s outdated, remove			affected.			
	medication for p	roper disposal"						
					The facility reviewed all medicate			
	The record for R	esident # 21 was			and treatments in the carts follow	ıng		
	reviewed on 2/9/	11 at 9:00 A.M.			the exit conference and no other residents were identified.			
					residents were identified.			
	On 02/8/11 at 1:1	15 P.M., an expired bottle			What measures will be put into			
		04% (eye drops) for			place or what systemic changes			
	Resident #21 wa				you will make to ensure that the	,		
		on the Moving Forward			deficient practice does not recur			
	incuication cart (on the moving rolward						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		155199	- 1	B. WING			011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			JNION ST		
MAPLE F	PARK VILLAGE			1	FIELD, IN46074		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	l '	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	unit. The bottle	contained a "use by					
	sticker" with the	date of 01/28. There was			The Licensed nurses and QMAs	were	
	no open date lab	eled on the medication.			inserviced on the storage of		
	_	ther open bottles of eye			medications and expiration policy	у.	
		n the medication cart for			Shift nurses are assigned to revie	w	
	Resident #21.	if the inedication care for			the carts for expired medications	vv	
	$\frac{1}{1}$				and/or appropriate medications		
					without open dates.		
	The resident's M	•					
		ecord) for February			Medications that are ready to exp		
		ility administered the eye			will be reordered by the nurse an	d	
	drops to Resider	nt #21 every night at			disposed of per policy.		
	bedtime from 01	/29/10 till 02/07/11.			N. F. C. 111 1 . I . I		
					Medications will be dated when opened. In the event that the date	,	
	During an interv	iew with the Assistant			open is not documented the facili		
	_	ing on 2/8/11 at 3:15			will go by the date delivered.	ity	
		ted all eye drops expire			win go by the date derivered.		
	90 days from op	ening.					
	3.1-25(o)						
					How the corrective action(s) wil	1	
					be monitored to ensure the deficient		
					practice will not recur, i.e., wha	t	
					quality assurance program will		
					put into place	-	
					The DNS/Designee will complete	e a	
					medication storage CQI audit on		
					medication and treatment carts		
					weekly for compliance.		
					The Pharmacy Tech will complet		
					monthly quality assurance review		
					the medication carts the results w be provided to the DNS. Issues	7111	
					identified will be addressed.		
					indication will be undicessed.		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILL	LDING	(X3) DATE SURVEY COMPLETED 02/10/2011
B. WING	G STREET ADDRESS, CITY, STATE, ZIP CODE	
I NAME OF PROVIDER OR SUPPLIER I	776 N UNION ST	
MAPLE PARK VILLAGE	WESTFIELD, IN46074	
	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL P	PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155199		A. BUILDING		COMPL	C3) DATE SURVEY COMPLETED 02/10/2011		
	PROVIDER OR SUPPLIER PARK VILLAGE	:		776 N L	JNION ST FIELD, IN46074		
	PARK VILLAGE SUMMARY S (EACH DEFICIENT REGULATORY OR Based on observed record review, the open date labels medication carts labels. The deficing Residents #1, #7 Findings included Director of Nursed A.M. titled, "Experimental compromised medicated, "with containers it is in "Date Opened" sed date is then dependent of the Moving observed. The medicated of the medicated of the Moving observed of the medicated o	cratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ation, interview and the facility failed to place on medications for 6 of 6 reviewed for open date client practice affected the practice	F04	776 N U WESTF ID PREFIX TAG	JNION ST	e th e s the he pen	(X5) COMPLETION DATE 03/08/2011
	and Travatan Z (on 1/24/11 for R had been opened date labels. On 02/09/11 at 1	ye drops) filled on 2/2/11 0.04% (eye drops) filled esident #7. Medications , but did not contain open :35 P.M., the medication e 100 hallway was			the exit conference and no other residents were identified. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur	•	

PRINTED: 03/08/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	155199 B. WING				<u> </u>	
NAME OF PROVIDER OR SUPPLIER MAPLE PARK VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 776 N UNION ST WESTFIELD, IN46074				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	observed. The mobottles of Travata for Resident #44. on 12/25/10 and were opened, but date labels. During an interview 3:15 P.M., he indica	ed cart contained 2 an Z 0.04% (eye drops) The bottles were filled 1/31/11. Both bottles did not contain open with the DON on 02/09/11 at ted the expiration date for the 90 days from the date the		TAG	The Licensed nurses and QMAs inserviced on the storage of medications, date open and expiration policy. Shift nurses are assigned to revie the carts for expired medications and/or medications without open dates. Medications that are soon to expirate will be reordered by the nurse and disposed of per policy. Medications will be dated when opened. In the event that the date open is not documented the facility will go by the date delivered. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place The DNS/Designee will complete medication storage CQI audit on medication and treatment carts weekly for compliance. The Pharmacy Tech will complete monthly quality assurance review the medication carts the results we be provided to the DNS. Issues identified will be addressed	ire dd e ity
					Compliance date: March 8, 201	1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

RWGY11 Facility ID:

000106

If continuation sheet

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